Part 1. General Information

433.401: Definitions

The following terms used in 130 CMR 433.000 have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 433.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 433.000 and in 130 CMR 450.000.

Acupuncture – the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Adult Office Visit – a medical visit by a member 21 years of age or older to a physician's office or to a hospital outpatient department.

Child and Adolescent Needs and Strengths (CANS) – a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members under the age of 21.

Community-Based Physician – any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician.

Consultant – a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a member's illness or disability.

Consultation – a visit made at the request of another physician.

Controlled Substance – a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery – a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to physical disease or defect, or traumatic injury.

Couple Therapy – therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service – a radiology service intended to identify an injury or illness.

Domiciliary – for use in the member's place of residence, including a long-term-care facility.

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency Admission Service – a complete history and physical examination by a physician of a member admitted to a hospital to treat an emergency medical condition, when definitive care of the member is assumed subsequently by another physician on the day of admission.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in §1867(e)(1)(B) of the Social Security Act, 42 U.S.C. §1395dd(e)(1)(B).

Emergency Services – medical services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

Family Planning – any medically approved means, including diagnosis, treatment, and related counseling, that helps individuals of childbearing age, including sexually active minors, to determine the number and spacing of their children.

Family Therapy – a session for simultaneous treatment of two or more members of a family.

Group Therapy – application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

High-Risk Newborn Care – care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

Home or Nursing Facility Visit – a visit by a physician to a member at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital-Based Entity – any entity that contracts with a hospital to provide medical services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Based Physician – any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital to provide services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Licensed Health Center – a facility that

(1) operates under a hospital's license but is not physically attached to the hospital;
(2) operates within the fiscal, administrative, and clinical management of the hospital;
(3) provides services to patients solely on an outpatient basis;
(4) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
(5) is enrolled with the MassHealth agency as a hospital-licensed health center with a separate hospital-licensed health center MassHealth provider number.

(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the MassHealth agency before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the MassHealth agency a written request detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The MassHealth agency will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the MassHealth agency will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.

(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(C) The MassHealth agency does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay a physician for the diagnosis of male or female infertility.

(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

The MassHealth agency pays for physician services with rates set by the ~~Massachusetts Division of Health Care Finance and Policy~~ Executive Office of Health and Human Services (~~DHCFP~~EOHHS), subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000. ~~DHCFP~~ EOHHS fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations, or successor regulations:

(A) 114.3 CMR 14.00: Dental Services

(B) ~~114.3 CMR 15.00~~101 CMR 315.000: Vision Care Services and Ophthalmic Services

(C) 114.3 CMR 16.00: Surgery and Related Anesthesia Services~~Care~~

(D) ~~114.3 CMR 17.00~~101 CMR 317.000: Medicine

(E) 114.3 CMR 18.00: Radiology

(F) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician or by an independent clinical laboratory certified by Medicare.

(B) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(B)(2), the MassHealth agency pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, the MassHealth agency pays only the laboratory for services provided for a member.

(2) A physician may bill the MassHealth agency for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following:

(1) a signed request for the laboratory services to be performed;
(2) the member's MassHealth identification number; and
(3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). ~~-~~However, the MassHealth agency will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. ~~-~~The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:

(1) tests performed to establish paternity;

(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and

(3) post-mortem examinations.

~~(130 CMR 433.440 Reserved)~~

433.440: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 433.440(C), for use as an anesthetic as described in 130 CMR 433.454(C), and for use for detoxification as described in 130 CMR 418.406(C)(3).

(B) General. 130 CMR 433.440 applies specifically to physicians and licensed practitioners of acupuncture.

(C) Acupuncture for the Treatment of Pain. MassHealth provides a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may receive more sessions of medically-necessary acupuncture treatment with prior authorization.

(D) Provider Qualifications for Acupuncture

(1) Qualified Providers.

(a) Physicians

(b) Other practitioners who are licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00 et seq.

(2) Supervising physicians must ensure that acupuncture practitioners for whom the physician will submit claims, possess the appropriate training, credentials, and licensure.

(E) Conditions of Payment. The MassHealth agency pays physicians, physician employers of an acupuncturist (in accordance with 130 CMR 433.401(F)), independent nurse practitioners licensed in acupuncture, or independent nurse midwives licensed in acupuncture for acupuncture services when the:

(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 243 CMR 5.00 et seq);

(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and

(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.

(1) Physicians, independent nurse practitioners licensed in acupuncture, and independent nurse midwives licensed in acupuncture may submit claims for acupuncture services when they provide those services directly to MassHealth members or as an exception to 130 CMR 450.301(A) when a licensed practitioner under the supervision of a physician provides those services directly to MassHealth members. See Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the physician, independent nurse practitioner licensed in acupuncture, or independent nurse midwife licensed in acupuncture may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

(2) Non-drug Product List. Payment for these items is in accordance with rates published in the Division of Health Care Finance and Policy regulations at 114.3 CMR 22.00: Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment and 101~~14.3~~ CMR 317.00: Medicine. The MassHealth Non-Drug Product List also specifies which of the included products require prior authorization.

433.443: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless

(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 433.444); and

(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of prescription or over-the-counter drugs or drug therapy.

(1) Cosmetic. The MassHealth agency does not pay for any drug used for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for any drug used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient, unless dispensed to a member who is a resident in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.

(5) Less-Than-Effective Drugs. The MassHealth agency does not pay for any drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(6) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(7) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for any drug when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.

(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 433.443(B). The limitations and exclusions in 130 CMR 433.443(B) do not apply to medically necessary drugs for MassHealth Standard enrollees under age 21. The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 433.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. (See 130 CMR 450.303.)

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for any drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307.

433.444: Pharmacy Services: Insurance Coverage

(A) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth ~~Standard~~ MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(B) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 433.443(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 et seq.

(C) Medicare Part D.

(1) Overview. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are

433.449: Fluoride Varnish Services

(A) Eligible Members. Members must be under 21 years of age to be eligible for the application of fluoride varnish.

(B) Qualified Personnel. Physicians, nurse practitioners, registered nurses, licensed practical nurses, physician assistants, and medical assistants may apply fluoride varnish subject to the limitations of state law. To qualify to apply fluoride varnish, the individual must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of the training, and provide such proof to the MassHealth agency upon request.

(C) Billing for an Office Visit and Fluoride Varnish Treatment or Procedure. A physician may bill for fluoride varnish services provided by the physician or a qualified staff member as listed in 130 CMR 433.449(B) under the supervision of a physician. The physician may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(D) Claims Submission. Physicians and independent nurse practitioners may submit claims for fluoride varnish services when they provide those services directly to MassHealth members. These are the only MassHealth provider types who may bill for this service independently under 130 CMR 433.449. A physician may also submit claims for fluoride varnish services that are provided by nurse practitioners, registered nurses, licensed practical nurses, physician assistants, and medical assistants according to 130 CMR 433.449(C). See Subchapter 6 of the *Physician Manual* for service codes.

(130 CMR 433.450 Reserved)

Part 3. Surgery Services

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency pays a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(B)(2) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for
(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries;
(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay for the diagnosis of male or female infertility;
(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury;
(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;
(5) services otherwise identified in MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 433.451 and 433.452, unless otherwise indicated.

(1) Complications Following Surgery – all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.

(2) Evaluation and Management (E/M) Services – visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.

(3) Intraoperative Services – intraoperative services that are normally a usual and necessary part of a surgical procedure.

(4) Major Surgery – a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines the preoperative period is one day and the postoperative period is 90 days.

(5) Minor Surgery – a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or 10 days.

(6) Postoperative Period –

(a) The postoperative period for major surgery is 90 days.

(b) The postoperative period for minor surgery and endoscopies is zero or 10 days.

(7) Postoperative Visits – follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.

(8) Postsurgical Pain Management – postsurgical pain management by the surgeon, including supplies.

(9) Preoperative Period –

(a) The preoperative period for major surgery is one day.

(b) The preoperative period for minor surgery is zero days.

(10) Preoperative Visits – preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

433.452: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Physician Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 450.000.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy. For payment information about obstetrical care, refer to 130 CMR 433.421.

(3) Submitting Claims for Certified Registered Nurse-Anesthetists. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of or who contracts with a CRNA, may submit claims for services provided by a CRNA, but only if such services are provided in accordance with 130 CMR 450.301(B). Only one provider may claim payment for the services provided by the CRNA.

(C) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture ~~only~~ as a substitute for conventional surgical anesthesia.

433.455: Abortion Services

(A) Payable Services.

(1) The MassHealth agency pays for an abortion service if both of the following conditions are met:

(a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and

(b) the abortion is performed in accordance with M.G.L. c. 112, §§12K through 12U, except as provided under 130 CMR 433.455(C)(2).

(2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one that, according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the woman's health.

(3) Unless otherwise indicated, all abortions referred to in 130 CMR 433.455 are payable abortions as defined in 130 CMR 433.455(A)(1) and (2).

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of abortion services. The MassHealth agency, any provider, or any agent or employee of a provider must not mislead any member into believing that a decision to have or not to have an abortion will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for abortion services as well as for all other medical services covered by MassHealth.

(C) Locations in Which Abortions May Be Performed. Abortions must be performed in compliance with the following.

(1) First-Trimester Abortion. A first-trimester abortion must be performed by a licensed and qualified physician in a clinic licensed by the Department of Public Health to perform surgical services, or in a hospital licensed by the Department of Public Health to perform medical and surgical services.

(2) Second-Trimester Abortion. A second-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform medical and surgical services; provided, however, that up to and including the 18th week of pregnancy, a second-trimester abortion may be performed in a clinic that meets the requirements of 130 CMR 433.455(C)(1) where the attending physician certifies in the medical record that, in his or her professional judgment, a nonhospital setting is medically appropriate in the specific case.

(3) Third-Trimester Abortion. A third-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for obstetric services.

(D) Certification for Payable Abortion Form. All physicians must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 433.455(D)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(D)(1), (2), or (3), the certification described in 130 CMR 433.455(D)(4) is required on the CPA-2 form. The physician must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Mother Would Be Endangered. The attending physician must certify that, in the physician's professional judgment, the life of the mother would be endangered if the pregnancy were carried to term.

(2) Severe and Long-Lasting Damage to Mother's Physical Health. The attending physician and another physician must each certify that, in his or her professional judgment, severe and long-lasting damage to the mother's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he or she is not an "interested physician," defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The physician is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending physician must certify that, in his or her medical judgment, for reasons other than those described in 130 CMR 433.455(D)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the mother's health.

433.456: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for a sterilization service provided to a member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 433.457, and such consent is documented in the manner described in 130 CMR 433.458.

(2) The member is at least 18 years old at the time consent is obtained.

(3) The member is not mentally incompetent or institutionalized.